No. 15,619

In the

United States Court of Appeals

For the Ninth Circuit

JOHN HANCOCK MUTUAL LIFE INSURANCE COMPANY, a corporation,
Appellant,

vs.

MARY TROUTFELT COHEN,
Appellee,

and

MARY TROUTFELT COHEN,
Appellant,

vs.

JOHN HANCOCK MUTUAL LIFE INSURANCE COMPANY, a corporation,
Appellee.

Brief of Plaintiff as Appellee and Reply Brief of Plaintiff in Support of Cross-Appeal

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Brief of Plaintiff as Appellee

In defiance of the express written obligation of a policy of life insurance, defendant has dragged the assured's widow through protracted litigation in the District Court, and now, after all ultimate questions of fact have been resolved against it by the findings, it resumes its attack here. In doing so, it makes statements having no support in the record and argues the case as if it were still in a trial court rather than a court of appeals.

STATEMENT OF THE CASE

The defendant is a life insurance company. Plaintiff is the widow and beneficiary of one Martin Troutfelt, hereafter called the assured. In 1939, defendant issued to the assured a 15 year endowment life policy of the face amount of $5,000, including a Supplementary Provision for Family Income. The latter provided that the assured (should he live so long) would pay an extra premium for *15* years, in return for which defendant would pay his widow $50 per month from the date of his death until the expiration of *20* years after the issuance of the policy, i.e., until 1959 (R. 36).

The assured accepted this policy, faithfully paid the stipulated quarterly premium of $104.30 (R. 62) for 25 quarters, and died in 1945 (Findings 6, 13, R. 102, 104). The plaintiff then surrendered the policy, with all the attached supplements and applications, to defendant for a determination of her rights. With physical possession of all these papers and of its own records, defendant executed a new and further promise on the policy reading as follows:

> "Insured died June 28, 1945. Settlement in accordance with Supplementary Provision for Family Income, dated February 24, 1939, attached hereto.
>
> John Hancock Mutual Life Insurance Company
>
> By: Elmer L. French,
>
> Secretary"

Defendant then returned the policy, so endorsed, to plaintiff (F. 10, R. 103).*

Defendant made the monthly payments to plaintiff through February 1, 1954 (F. 13, R. 104). Then, although there were still 5

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*For some reason unknown to plaintiff, this endorsement has not been reproduced with the remainder of the policy at pp. 31-36 of the record. We ask that the Court consult the original policy which is in evidence (R. 124).

years to go, and 9 years after making the ratification and promise just quoted, 9 years after the husband's mouth was closed by death, and 15 years after the policy was issued, defendant notified plaintiff that it would make no more monthly payments and offered the $5,000 face amount as full discharge of its obligations (F. 13, 14; R. 104).

Defendant thereby repudiated its obligation and committed an anticipatory breach of contract (F. 14, R. 105).

Its excuse is the claim that its own written policy was not its contract, that the figure 20 had been written in the Family Income provision by a clerk's mistake (R. 23), although it had never said so to the assured at all or to the widow prior to this repudiation (R. 43, 140). It argues that the "true agreement" of the parties was that the assured was to pay the extra premiums for 10 years, if he lived so long, although the policy specifies 15,* and that his widow should receive only 15 years of family income protection, although the policy specifies 20.

The foundation of defendant's excuse lies in the fact that, in applying for the policy, the assured signed an application form for the family income supplement (R. 37, 61). Item 11 on the form read, "Term of the Supplementary Provision ..... years" with the notation under the blank "Insert 10, 15 or 20". Item 14 read "Premium to be paid for ..... years" with the notation under the blank, "Insert 5, 10 or 15". All blanks in the forms were filled out in handwriting, except that the assured's name, the numeral "15" in item 11, the numeral "10" in item 14, and the amount of premium were inserted in typewriting (R. 37, 61).

It will be noted that the policy as written, issued and delivered by defendant to, and accepted by, assured increased *each* period by 5 years—i.e., both premiums and family income were to be paid for 5 more years (R. 36).

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*Since the assured died within 6 years, this argument takes nothing out of defendant's pocket.

Defendant admits that a contract of insurance *was* entered into between itself and the assured (R. 42, 127; D. Br. 12).* But it argues that the contract was not in the terms of the policy which it issued and he accepted but in the terms *purportedly* stated in the application.

The District Court found the fact to be otherwise: it found the contract to be precisely as issued and accepted (F. 4, 5; R. 101, 102).

In essence, the prime question on appeal is simply whether the findings are unsupported by the evidence. As we shall see, a finding in favor of defendant would itself have been completely erroneous.

ARGUMENT

I. The Contract Found by the Trial Court Was the Only Contract or Agreement Entered into by the Parties. Moreover, it Was Ratified in 1945.

Defendant is compelled to admit that there was a contract between the parties, because (a) it accepted premiums for years, and (b) essentially its claim is one for reformation (R. 26), and there can be no reformation unless both parties actually reached a complete *mutual understanding*. As said in *Bailard v. Marden,* 36 Cal. 2d 703, 708, 227 P.2d 10, 13,

> "if no agreement was reached, there would be no standard to which the writing could be reformed."†

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*In order to avoid confusion between the parties, we use the notation "D. Br." to refer to the green brief of defendant John Hancock entitled "Appellant's Opening Brief."

†Defendant labors an argument (D. Br. 19, et seq.) that to permit reformation it is not necessary that there be a prior enforceable contract but only that there be a prior accord or meeting of the minds. The law is that there must have been a "complete mutual understanding of all the essential terms of their bargain" assented to by both sides. 5 Williston on Contracts, (Rev. Ed., 1937) p. 4339; *Hayes v. Travelers Ins. Co.,* 93 F.2d 568, 570 (10 Cir.). It may be unenforceable because not in writing where writing is required by the Statute of Frauds or where the parties intend it to be reduced to writing, or because other subjects are intended to be covered in the final contract, but the parties must have "expressed agree-

Here, there was no proof of any such mutual understanding prior to the assured's acceptance of the insurance policy itself.

The fact, if it be a fact (see pp. 7-8 *infra*), that the assured's application for family income spoke of 10 years of premiums and 15 years of protection is irrelevant. It is no evidence, let alone compelling evidence, that the parties agreed to this. The application was not an agreement; there could be no agreement on those terms unless and until defendant agreed to them. This is obvious, both as a matter of law, and from the face of the application, for immediately above applicant's signature appear the words (R. 37):

> "It Is Understood and Agreed * * *
>
> B. *That any Supplementary Provision for Family Income which may be issued hereon* shall take effect only if * * * it shall be delivered to and actually received by me and the first premium or instalment thereof actually paid while I am alive and in sound health, and that delivery and payment shall constitute an acceptance of the Supplementary Provision for Family Income and of all its conditions."*

At most the application was but an offer; and it was not accepted, for the policy as issued was then itself a counteroffer which ripened into a contract when the assured accepted it and paid the premiums. It was stipulated that none of the persons authorized to bind the defendant ever communicated to the assured that it agreed to the terms of the application (R. 132), and there is no evidence that even an unauthorized agent did so. Defendant's responses to plaintiff's request for admissions numbered 9 and 10 constitute, as a matter of law, an admission that there was no such communication (R. 28, 42). Defendant intended to remain *wholly uncommitted* until it not only decided *whether* it would enter into an agreement but *what* agreement would be satisfactory to it. It made

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ment and *an intention to be bound* in accordance with the terms that the court is asked to establish and enforce." 3 Corbin on Contracts, Sec. 314, p. 464.

*Throughout this brief all emphasis is supplied.

no communication with assured before sending him the policy sued on (R. 136). When the policy was delivered to the assured, he had the choice of either accepting or rejecting it. 29 Am. Jur., Insurance, § 155. He did precisely what the application provided he should do to enter into a contract, viz., he accepted it and paid the premium. No authorized agent of defendant ever informed the assured that he would not have to pay the premiums for 15 years, as provided in the rider (R. 28, 139), and there is no evidence that even an unauthorized agent did so.

The case is similar to *Metropolitan Life Ins. Co. v. Banion,* 106 F.2d 561 (10 Cir.), where the policy provided, as does the policy in suit, that the application was "a part" of the contract (p. 566):

> *"But an insurance company may make a binding contract of insurance by issuing and delivering the policy and accepting the premium upon it, even though the insured applied for a different kind of policy.* The issuance, delivery, and acceptance of the policy, and the payment, acceptance, and retention of the premium can constitute an enforceable contract of insurance despite the fact that it departs in some respects from the policy outlined in the application."

In *Metropolitan Life Ins. Co. v. Whitler,* 172 F.2d 631 (7 Cir.) the court said (p. 633):

> "an application for life insurance itself is not the contract, but is a mere offer or proposal for a contract of insurance. It is merely a step in the creation of the insurance contract. 29 Am. Jur. p. 152. And where the insurance company tenders a policy at variance with the application, the tender constitutes a counter-offer, and upon acceptance of the policy by the insured, there is a meeting of the minds and the policy becomes the contract between the insured and the insurance company (citations) * * * even where an application is made a part of the policy and there is an irreconcilable conflict between the application and the policy issued, the provisions of the policy control" (citations)

In short, either the Supplementary Provision, *as written by defendant,* is the contract, or there never was any contract at all. There is no in between situation. There is not a shred of evidence that the parties ever agreed to anything other than the 15 and 20 year arrangement set out in the policy as written.

THERE IS NO EVIDENCE THAT ASSURED INTENDED OR AGREED TO REDUCE HIS WIFE'S PROTECTION.

Thus far we have assumed, for the argument, that the assured in fact applied for a 10 and 15 year arrangement. But this is an unestablished assumption.

There was no evidence of the oral negotiations between the assured, who was dead, and the defendant's soliciting agent. Defendant failed to call either the witness to the application or the agent (R. 37), although preparatory to trial defendant interviewed him (R. 132). Thus defendant's argument is a superstructure resting on a pure *assumption* that the numerals "10" and "15" were in the application when the assured signed it, although these were patently typed into blank spaces, whereas the other blanks were filled in by longhand (R. 61).

While defendant's clerk Lawton (R. 157) testified that these blanks were filled in before signature (R. 172), his credibility was a question for the trial judge, who was not required to believe him. R.C.P. Rule 52; *Hayes v. First Nat. Bank of Fairbanks,* 192 F.2d 393, 394 (9 Cir.); *Sun Life Assur. Co. of Canada v. Stacks,* 187 F.2d 17, 20 (7 Cir.). In view of the findings it must be inferred that the court disbelieved him. *Standard Oil Co. v. Moore,* ..... F.2d ..... at ....., CCH Trade Reg. Rep. ¶ 68,861 (9 Cir., No. 14,927; Nov. 6, 1957) slip. opinion, p. 7. And there were excellent reasons why the court should have disbelieved him:

1. Lawton had no personal knowledge of the subject. He neither prepared nor knew where the paper had been prepared (R. 171, 186). His testimony was an attempt to *reconstruct* by speculation what had happened, on the basis of some correspond-

ence he had last seen, if at all, 16 years before, the contents of which he could not recall (R. 188, 189), and which was not produced.

2. The policy was issued in 1939. But it supplanted another issued earlier in the same year. The earlier one was a 20-pay life policy, but in the same face amount of $5000 and with the same family income supplement requiring payment of premiums during assured's lifetime for 15 years and providing 20 years of income payments (D. Br. 4). The assured applied to convert this to a 15 year endowment policy, and as part of that application signed the application for the family income supplement (R. 37). The earlier policy called for premium payments of $66.60 per quarter (R. 66, 162). The later one provided for premium payments of $104.30 per quarter (R. 62). In merely changing from a 20-pay life to a 15 year endowment policy, no reason appears why the assured should have wanted to reduce his widow's income protection by ¼ (from a maximum 20 years to a maximum 15 years) in the very course of increasing the premium obligation by over 50%. The trial court was entitled to infer that he did not do so. Any reasonable inference to sustain the findings of fact must be drawn. *Standard Oil Co. v. Moore*, ... F.2d ....., CCH Trade Reg. Rep. ¶ 68,861 (9 Cir., Nov. 6, 1957).

The burden of establishing that the application had been filled out before signature was on defendant. Plaintiff relies on a contract formed by the assured's acceptance of the policy issued and delivered to him by defendant. It is defendant who argues that something else was agreed to; the burden of establishing every element of that contention by clear and convincing evidence rested on it.

IN 1945 DEFENDANT RATIFIED AND MADE A NEW PROMISE TO PAY THE POLICY AS WRITTEN.

It is admitted (R. 41, 126) and found (F. 10, R. 103) that in 1945, upon her husband's death, plaintiff surrendered the entire

policy to defendant as part of her claim and proof as beneficiary. *This* was the time when defendant was called upon to decide what its obligations were under the very supplement here sued on. Defendant's brief asserts that its purpose in calling for the policy was to furnish the beneficiary with a written record that the policy had been processed for payment (D. Br. 26). In its "Brief of Cross-Appellee in Answer to Cross-Appeal", in attempting to escape a warranty on which plaintiff claims an amount of damages measured by attorney's fees, defendant construes the warranty there involved as imposing the obligation "when facts occur that relate to [a] policy * * * [to] investigate and tell [the beneficiary] if these facts entitle you to payments" and to "help [the beneficiary] to perfect [her] claims and rights under the insurance contract" (Brief, p. 4).

In this posture, and with all the documents before it, defendant endorsed the policy and returned it to plaintiff. The endorsement placed thereon read (F. 10, R. 103):

> "Insured died June 28, 1945. Settlement in accordance with Supplemental Provision for Family Income dated February 24, 1939 attached hereto."

This endorsement does *not* state that defendant is to pay "in accordance with the application", or in accordance with some unwritten meeting of the minds of the parties. It points to a *specific* document dated February 24, 1939 which plainly provided for a 20-year period.

Consequently, it is irrelevant whether anybody made a mistake in 1939, six years earlier. The defendant's new act of 1945 ratified the family income supplement *as written.* An insurance company, like anyone else, can ratify what purports to be its contract. 44 C.J.S., Insurance, § 273; 29 Am. Jur. Insurance § 98. No consideration is necessary to make the new promise and ratification binding. 1 Corbin on Contracts § 228; Restatement of Contracts § 89; 2 C.J.S. Agency, § 43; 2 Am. Jur. Agency § 210. The only

requirement is that the insurer know what it is doing at the time or have "the equivalent of knowledge, such as an opportunity to acquire information" (44 C.J.S., Insurance p. 1089); Restatement of Contracts § 93.

The District Court *found* that *when plaintiff surrendered the policy* in 1945 "defendant thereupon had the opportunity to read and should have read said policy" (F. 10, R. 103). Defendant does not attack this finding,* and it has never claimed or offered any evidence that any mistake was made *in 1945* or that it did not actually then read the entire policy. As quoted by this Court with approval in *Fidelity & Guaranty Fire Corporation v. Bilquist,* 108 F.2d 713, 716 (9 Cir.):

> "Appellant is presumed and is required to know the provisions of the insurance contract, as it would any other written contract into which it enters. It will not do for appellant's vice president to say that he did not read the policy. Whether he or any of the other officers or agents of appellant read the policy is immaterial. It was appellant's duty to read the policy, and the law states that that was done."

Accord: *Hayes v. Travelers Ins. Co.,* 93 F.2d 568, 571 (10 Cir.); *Palmquist v. Mercer,* 43 Cal. 2d 92, 98, 272 P.2d 26, 30.

DEFENDANT'S OWN ARGUMENT THAT THE CONTRACT IS AMBIGUOUS REQUIRES AFFIRMANCE.

Defendant argues that the unequivocal promise to pay during a period of 20 years, in consideration of assured's paying premiums for 15 years, is "ambiguous", because inconsistent with the application (D. Br. 12). As we have seen, the application is no measure of the parties' contract. But even apart from that, the argument administers the coup de grace to defendant.

It is elementary that if the application is deemed part of the contract, and if there is a conflict between the policy and the

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*Cf. Defendant's Designation of Points (R. 219) and its Specification of Errors (D. Br. 7).

application, the provisions of the policy control. *Aetna Life Ins. Co. v. Phillips,* 69 F.2d 901, 904 (10 Cir.); *Horning v. Lindsay,* 169 F.2d 963, 964 (D.C. Cir.).

Defendant quotes a headnote from *Castellina v. Vaughan,* 11 S.E. 2d 536, 122 W.Va. 600, for the proposition that the application controls. But a reading of the case shows the law of West Virginia to be that control is given to whichever document benefits the insured. E.g., *Logan v. Provident Sav. Life Assur. Soc.,* 50 S.E. 529, 57 W.Va. 384. This conforms with the elementary principle that any uncertainties or ambiguities in contracts of insurance must be resolved most strongly in favor of the insured, including resolution in favor of the greatest indemnity or coverage. *Continental Casualty Co. v. Phoenix Construction Co.,* 46 Cal. 2d 423, 437, 296 P.2d 801, 809, and numerous cases there cited.*

"The policy should be read as a layman would read it and not as an attorney or an insurance expert might read it." *Hobson v. Mutual Benefit H. & A. Association Inc.,* 99 C.A. 2d 330, 333, 221 P.2d 761, 763. The Supplementary Provision for Family Income plainly states that the income is to be paid for 20 years after 1939. Imagine a layman, with a written promise before him of 20 years' payments *(in numerals 1/4 inch high),* "construing" this promise with the application and concluding that 20 "meant" 15! But, in fact, the "experts" read it just as the assured read it. Defendant's execution of the promise in 1945 to pay in accordance with the Supplementary Provision (see pp. 8-10, *supra*) was a construction that the policy meant just what it said.

Defendant argues (D. Br. 13) that where an ambiguity exists, the court has a "preliminary job of construction" and to that end

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*Defendant also cites *Bass v. Occidental Life Ins. Co.,* 142 Pac. 798, 19 N.M. 193. The case is not in point. There, a blanket policy was issued by the insurer to the employer covering those employed by it as miners. To determine whether plaintiff was so employed and therefore covered, it was necessary to refer to the written contract between the employer and plaintiff employee. Both contracts were essential to the existence of the cause of action.

"parol evidence and the history of the transaction and any other relevant circumstances should be examined". True, but the court received the evidence defendant offered, and in that situation construction is a question of fact, and the trial court's finding is conclusive unless clearly untenable. *Estate of Rule,* 25 Cal. 2d 1, 152 P.2d 1003.

We submit that the foregoing wholly disposes of the case. The following discussion summarizes further reasons why the judgment should be affirmed, and answers other arguments of defendant that belong in a trial court.

II. There Was No Mutual Mistake, or Any Form of Mistake Permitting Reformation or Constituting a Defense, or Mistake at All.

Based on the abstrusities of its private rate schedules, defendant argues that it made a mistake. But it is the external manifestation or expression of mutual assent which creates an agreement. Restatement of Contracts § 20. As stated by the Restatement of Contracts § 503, comment a,

> "There is a contract formed by the acceptance of an offer even though the offer is made under a mistake * * *. The objective appearance of his acts is controlling * * *"

The record shows only one such manifestation—defendant's offer of a contract in the terms of the written policy and the assured's acceptance.

To permit one to escape or reform the contract, the mistake relied on must be either mutual, or a mistake of one party which the other at the time either knew or suspected. Cal. Civil Code § 3339; *Goodfellow v. Barritt,* 130 Cal. App. 548, 556, 20 P.2d 740, 743; *Miller v. Lantz,* 9 Cal. 2d 544, 548, 71 P.2d 585, 587; *Messner v. Mallory,* 107 C.A. 2d 377, 381, 236 P.2d 898, 900; Restatement of Contracts §§ 503, 504, 505. The burden is upon him who claims a mistake to establish it *by clear and convincing*

evidence. Moore v. Vandermast, Inc., 19 Cal. 2d 94, 119 P.2d 129; *H. Moffat Co. v. Rasasco,* 119 C.A. 2d 432, 442, 260 P.2d 126, 133; *Franciscan Hotel Co. v. Albuquerque Hotel Co.,* 24 P.2d 718, 724, 37 N.M. 456; Restatement of Contracts § 511.

Thus defendant had to prove (1) not only a mistake on its part, but in addition (2) that the assured made the same mistake or knew that defendant had made a mistake.

A. THE FINDINGS.

Contrary to defendant's assertions (D. Br. 15), the District Court did *not* find that it made a mistake.* And most explicitly the court did find that the assured neither knew nor suspected any mistake, nor reasonably could or should have known or suspected one (F. 7; R. 102).

B. THE EVIDENCE SUPPORTS THE FINDINGS.

If, in the policy as issued, only the period during which income would be payable had been stepped up 5 years over the period inserted in the application, there might be more substance to a claim of clerical mistake. But the period during which premiums were payable was also stepped up. This alone warranted the trier of fact in concluding that the changes were deliberate on the part of responsible officers of the insurer, not a clerk's inadvertence.

Defendant merely introduced the testimony of a local clerk in San Francisco (R. 157) that defendant would never issue this kind of policy. This was a pure conclusion based entirely on defendant's rate book (R. 164, et seq.). But it was not the clerk's function to

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*In its opinion, the trial judge stated that defendant made a mistake (R. 76) and thereafter at a hearing on the settlement of the findings referred to "a clerical mistake" (R. 199), but when it came to make its findings it made no finding of mistake (R. 100-105). The opinion of a trial court cannot be used to impeach the judgment, or to control or modify the findings on which it is based. *Isaacs v. De Hon,* 11 F.2d 943, 944 (9 Cir.); *United States v. Flower,* 108 F.2d 298, 301 (8 Cir.); *American Ins. Co. v. Lucas,* 38 F. Supp. 926, 938.

make such decisions. None of the numerous employees who *did* have that function and did pass on the policy saw anything in the policy as issued incompatible with defendant's rate structure.

The policy was written by defendant's agent "D. Mc. G." (R. 62). It was then checked by one "K.M.H.", who then turned it over to the policy registrar ("F.G.B.") who countersigned it for the defendant (R. 31). Thus, before the policy even left Boston, no less than three of defendant's agents had scrutinized it. *No one of these persons thought there was any mistake, saw anything unusual, or testified.* Indeed, by answer to a pre-trial interrogatory, defendant stated that it intended to rely on the testimony of F. G. Bowen, the policy registrar. (R. 46, 58, 59). But without any explanation, Bowen's testimony was not adduced by defendant, by deposition or in person. This silence was in itself "evidence of the most convincing character" that Bowen's testimony would have been unfavorable to defendant. *Interstate Circuit v. U. S.,* 306 U.S. 208, 226; *Hann v. Venetian Blind Corporation,* 111 F.2d 455, 459 (9 Cir.); Cal. C.C.P. § 1963(5).

Six years later the beneficiary sent the policy to the defendant for payment. Its Secretary wrote on it to pay "in accordance with the Supplementary Provision for Family Income." *Neither he nor anyone else who handled the policy at this time saw anything unusual, or testified.*

Moreover, the assured knew nothing about defendant's rate book, nor is it likely that any layman could have understood it had he known of it. The District Court itself remarked, "As a matter of fact, I doubt my ability to read the rate book accurately." (R. 166) Under the original 20 pay life policy issued in early 1939, the premium of $66.40 per quarter was a construction of 5 items (R. 66). Under the substitute 15 year endowment the premium of $104.30 per quarter was also a construction of 5 items (R. 62), some of which were greater and some less than the corresponding items on the earlier policy, although the total was greater. Even had he seen the constructions no layman could have

made heads or tails out of them so as to suppose that any facet of the premium was out of line with the coverage written.*

Repeatedly courts have rejected arguments of insurance companies based on their ratebooks and actuarial paraphernalia as expecting too much of laymen. E.g., *Metropolitan Life Ins. Co. v. Asofsky,* 38 F. Supp. 464; *National Fidelity Life Ins. Co. v. Gerard,* 52 P.2d 1, 175 Okla. 219; *New York Life Ins. Co. v. Dickensheets,* 193 P.2d 649, 165 Kan. 159.

Patently, the District Court was warranted in its finding.

C. DEFENDANT'S ARGUMENTS.

Defendant is driven to arguing that under New Mexico law, it is "irrelevant whether the insured knew or should have known" of the alleged mistake (D. Br. 17). We need not digress to consider whether New Mexican law applies, because the law of New Mexico is the same as the law everywhere else, i.e., a mistake must be mutual, not merely unilateral. *First National Bank v. Hartford Fire Insurance Co.,* 127 Pac. 1115, 17 N.M. 334; *Cleveland v. Bateman,* 158 Pac. 648, 21 N.M. 675; *Collier v. Sage,* 180 P.2d 242, 51 N.M. 147.

Defendant relies on *Point v. Wills,* 97 P.2d 374, 44 N.M. 31. But the court there first stated the settled principle as requiring mutual mistake, *then quoted an argument urged by the insurer in that case,* and then declined to apply that argument (p. 378). Defendant's brief merely quotes the losing party's argument as if it were the court's statement of law.

Moreover, defendant's argument rests on the assumption that prior to the issuance of the written policy the parties had come to an agreement, and that is a false assumption, as already seen.

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*The basis of the conclusion of defendant's witness was his testimony that the extra premium on a family supplement with premiums payable for 15 years and affording 20 years protection was $52.95 per annum (R. 165). The amount provided for in the policy from the assured was $43.20 per annum (R. 33), a difference of $9.75 per year or about *3 per cent* of the total annual premium. It is this mote on which defendant bases its argument that the assured gave "no consideration" for the policy sued on (although he paid just what defendant told him to) and that his widow seeks a "windfall"! (D. Br. 24).

Defendant next argues (D. Br. 23) that even though it may not secure reformation, it can assert its own alleged mistake as a "defense", citing *Chaplin v. Korber Realty*, 224 Pac. 396, 29 N.M. 567. That case does not support the defendant, for it was a suit in equity for specific performance, and the mistake had occurred without negligence by one exercising the care and diligence which should be exercised by a person of ordinary care and prudence. In such a case the court held that specific performance of a bargain found to be harsh and inequitable would not be granted, because specific performance is an equitable remedy "not granted as a matter of course, or as an absolute right, like the right to recover a judgment at law", and that the parties would be left "to their remedies at law". Here plaintiff has sought no equitable remedy. She sued purely at law.

Here, too, if there was a mistake, defendant was negligent, and here, too, the shoe is on the other foot about harsh and inequitable conduct.

As said in *Royal Ins. Co. v. City of Morgantown,* 98 F.Supp. 609, 612,

> "a court of equity will not relieve a party from a mistake caused by his own gross negligence. This principle is applicable in this case. To begin with, the policy was physically typed by an experienced agent of the company. It was checked in the Wheeling office * * * in the Charleston office * * * and by at least two in the home office of the company itself. Surely, somewhere along this line the mistake, if it was a mistake, should have been discovered."

III. Defendant's Counterclaim, as Well as Its So-Called "Defense", Is Barred by Limitations.

As defendant agrees (D. Br. 25), California law governs the issue of the Statute of Limitations. *Ragan v. Merchants Transfer Co.,* 337 U.S. 530. The specific statute is California Code of Civil Procedure, Sec. 338(4) whereunder a claim of mistake must be asserted within 3 years, with the exception that the claim is timely if the mistake was not "discovered" until within three years of suit.

To come within the exception the party asserting late discovery has a strict burden of pleading and proving not only late discovery but also facts excusing the delay. The rules are fully stated in *Consolidated R. & P. Co. v. Scarborough,* 216 Cal. 698, 16 P.2d 268, and have been consistently applied in mistake cases. E.g., *Miller v. Lantz,* 9 Cal. 2d 544, 548, 71 P.2d 585, 587; *Johnson v. Ware,* 58 C.A. 2d 204, 207, 136 P.2d 101, 103; *Goodfellow v. Barritt,* 130 Cal. App. 548, 557, 20 P.2d 740, 744.

"Discovery" is a question of fact for the trial judge, *Uchida Investment Co. v. Inagaki,* 108 C.A. 2d 647, 654, 239 P.2d 644, 649, and here the District Court found that defendant discovered the mistake, if any, in 1939 or at the latest in 1945 (F. 12, R. 104). This finding disposes of the issue, unless defendant sustained its burden of proof so conclusively that the finding is clearly erroneous. In fact, a contrary finding would have been unthinkable.

A mistake, if any, occurred in *1939* when the policy was written. Not until 15 years later, in 1954, did defendant inform anybody of any claimed mistake (R. 43, 140) or assert it in this action (R. 18). The only evidence on the subject was that the policy was written, checked, and signed in 1939, and that defendant had the policy in its possession in 1945 and endorsed on it the promise to pay according to its terms. It conclusively follows that defendant read the policy in 1945 and is chargeable with full knowledge of its contents. *Fidelity & Guaranty Fire Corp. v. Bilquist,* 108 F.2d 713, 716 (9 Cir.), quoted at p. 10, *supra.*

Defendant offered *absolutely no evidence* respecting when, how or by whom the supposed mistake was discovered. None of the persons who had anything to do with the policy in 1939, or again in 1945, testified. As the trial judge observed, *nothing* was offered by way of excuse; there was simply *no* proof (R. 78). Defendant made no effort to sustain its burden. The assertions in its brief that it had no "actual knowledge" and that "the mistake came to light only when plaintiff refused to accept the final payment" (D. Br. 28) are gratuitous without the citation of any record references.

The gist of defendant's argument is that it had no "duty to investigate the terms inserted in the written copy of the insurance policy" or to pay any attention to what it read and solemnly re-endorsed! (D. Br. 29). This grotesquerie amounts to a claim that while the assured, a layman, is to be charged with knowledge that a policy issued to him in 1939 did not and could not mean what it said, the defendant through insurance experts is not to be charged with knowledge or comprehension of the same policy or its records! Unwittingly, defendant has destroyed its own argument. In the brief filed by it in answer to plaintiff's cross-appeal, it states (Brief of Cross-Appellee in Answer to Cross-Appeal, p. 4):

> "The company *takes upon itself the obligation to investigate* the claim of the insured when it is given notice that such a claim exists.
>
> * * * * * * * * *
>
> "The provision * * * says in effect 'come to us, when facts occur that relate to your policy; *we will investigate* and tell you if these facts entitle you to payments * * *' "

By its own confession defendant *did* have the duty to investigate when in 1945 plaintiff made a claim and submitted the policy to defendant.

Defendant pleaded that it made discovery the moment a copy of the policy came into its hands in 1954 (R. 25). It could just as easily have done so when it had the policy itself *nine years earlier.* If it did not, it was guilty of gross negligence. As stated in *Beresford v. Horn,* 127 C.A. 2d 89, 92, 273 P.2d 302, 304:

> "The law does not countenance indifference in such matters. It does not recognize ignorance which is due to negligence as an excuse for inaction."

To the same effect: *Messner v. Mallory,* 107 C.A. 2d 377, 381, 236 P.2d 898, 900.

Defendant cites *Mutual Life Insurance Co. of N. Y. v. Simon,* 151 F. Supp. 408 (S.D. N.Y.). The case is wholly dissimilar.

There the policyholder was alive and *conceded* that the sum payable should have been $5,798.26 instead of the preposterous sum of $57,093.28 as written; elaborate evidence was introduced respecting the preparation of the policy, including the testimony of the scrivener; and when the policy was in the hands of the insurer's local agency it was *not* for the purpose of determining what sum should be paid, but for the addition of riders which had nothing to do with the concededly erroneous provision. There the trial court found that the evidence "clearly established" that the insurer did not discover the mistake until shortly before suit. Here, the finding is that the discovery occurred no later than 1945.

THE BAR OF THE STATUTE OF LIMITATIONS APPLIES TO THE "DEFENSE" OF MISTAKE AS WELL AS TO THE COUNTERCLAIM FOR REFORMATION.

Defendant next argues (D. Br. 31) that although a suit or counterclaim for reformation for mistake may be barred, the statute of limitations never bars a defense on the ground of mistake. Defendant phrases the contention thus, that an insurer may "abide its time" and await suit (R. 150). But, bluntly, it means that an insurer may "lie in the grass"; it may solemnly issue and deliver its written promise to pay and, although it knows or learns of an alleged mistake therein, lie supine, accept the premiums year after year, await the insured's death, promise the beneficiary that it will pay "in accordance with Supplementary Provision for Family Income * * * attached hereto"—and then, 15 years after writing the policy, and 9 years after the insured's death, assert its claim of mistake!

Whatever may be the rule with respect to a defense that the plaintiff committed a fraud, this is not the rule when the defense is that defendant made a mistake. The difference is patent, for to sit silent after knowledge of one's own mistake is to acquiesce, to ratify, to waive.

The authorities are clear. When a defendant seeks to vary the terms of a contract, when sued on it, by setting up mistake, plain-

tiff may invoke limitations. *Miller v. Lantz,* 9 Cal. 2d 544, 71 P. 2d 585; *Bradbury v. Higginson,* 167 Cal. 553, 140 Pac. 254; *Sanders v. Sanders,* 117 Cal. App. 231, 3 P.2d 599.

In *Sanders v. Sanders,* supra, affirming a judgment for the plaintiff for amounts provided in a contract, the court said (117 Cal. App. at 233, 234, 3 P.2d at 600):

> "The question present for determination is, therefore, whether a plaintiff may invoke the statute of limitations against an affirmative defense based on allegations of mistake, wherein the defendant is seeking reformation and cancellation of the instrument sued upon, *the contention of defendant herein being that a party may bide his time and, when enforcement is sought against him, interpose such defense and obtain such relief, regardless of lapse of time.* The decision in the case of *Bradbury v. Higginson,* 167 Cal. 553 [140 Pac. 254] evidently holds to the contrary, and in our opinion is decisive of this appeal."

Defendant rests on *Bank of America v. Vannini,* 140 Cal. App. 2d 120, 295 P.2d 102, a *fraud* case which quotes only enough from 1 Witkin, California Procedure, 601 to dispose of that case. Reference to Witkin shows that he is speaking of "defenses which render the contract *wholly unenforceable*". There are two different kinds of cases involving mistake. In the one, either there is a contract in the exact terms as written or, because of mistake, there never was any contract at all. In that situation reformation is not obtainable (see page 4 supra), and mistake, like fraud, or failure of consideration, may be set up as a defense at any time, for the defense is "no contract". But there is another kind of mistake, where it is admitted that there *was* a contract of some terms, but it is claimed that the wrong terms were written. In that kind of case there was no defense at law, but equity gave the remedy of reformation. In the reformed procedure adopted in the Code states and later in the Federal Rules of Civil Procedure, where law and equity are merged, the defense of mistake in that kind of case is

merely a shorthand procedure to obtain reformation. But if reformation is barred, so is the "defense", for the reform of procedure did not alter substantive rights. Thus, in *Bradbury v. Higginson,* 167 Cal. 553, 140 P.2d 254, an action on a written lease for rent, the tenant's answer alleged that by mistake a certain covenant had been omitted from the lease. Judgment was rendered for plaintiff on demurrer to the answer because of limitations prescribed by Cal. Code of Civil Procedure § 338(4). The court said (167 Cal. at 557, 140 Pac. at 255):

> "The reformation of contracts is a branch of the equity jurisdiction. Under the old system, where legal and equitable rights were administered in different tribunals, the equitable remedy would have had to be sought and obtained in a court of chancery in a suit instituted for that purpose. Under our procedure, however, equitable defenses may be interposed to legal causes of action, and a right to equitable relief, affecting the legal right asserted in the complaint, may be set up by answer. *But if the matter set up be an equitable cause of action, the answer must contain all the averments essential to the statement of a cause of action as such (citing cases). If the defendant's right to obtain the equitable relief sought is barred by limitation, the plea of the statute may be interposed to the attempted defense just as it might have been in case the relief had been sought by an independent action* * * *"

Sanders v. Sanders, 117 Cal. App. 231, 3 P.2d 599, made the same distinction (117 Cal. App. at 235; 3 P.2d at 600):

> "Defendant has also cited a number of cases adhering to the well-established rule that in actions to enforce agreements the statute of limitations may not be invoked against the defense of fraud. (*Estate of Cover,* 188 Cal. 133.) Of course, in such cases, the defense of fraud may be interposed at any time, and, if established, renders the instrument *void and unenforceable from the beginning. But our attention has not been called to any case wherein the same rule has been applied to an affirmative defense based on mistake* * * *"

IV. Defendant's Claim Is Barred by the Incontestability Clause of the Policy.

The policy contains the following clause on "Incontestability and Limitations" (R. 31):

> "This policy, except any supplementary provision hereof granting any benefit for total and permanent disability, or granting any additional insurance specifically against death caused by certain bodily injuries sustained through accidental means, shall be incontestable after it has been in force during the lifetime of the Insured for two years from its date of issue, except for non-payment of premium, and except that if the Insured's age has been misstated the amount payable hereunder shall be that which the premium paid would have purchased at the correct age.
>
> "If the Insured shall die within two years from the date of issue of this policy by self-destruction, while sane or insane, the amount payable hereunder shall be limited to the premiums paid hereon."

This Court has squarely held in *Richardson v. Travelers Insurance Co.,* 171 F.2d 699 (9 Cir.) that an incontestability clause precludes the insurer from asserting a claim of mistake so as to defeat recovery. And the facts of the present case illustrate the wisdom of the *Richardson* rule, for, as there stated (p. 701):

> "[T]he origin of the clause may be found in the competitive idea of offering to policyholders assurance that their dependents would be the recipients of a protective fund *rather than a lawsuit.*"

The *Richardson* decision has been criticized along lines argued by defendant below, that it was not contesting against the terms of the policy, but for or in favor of its terms. There may be types of cases where that argument has some substance.* But here

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*E.g., if a policy provides that coverage shall be adjusted if the insured has misstated his age, or that liability is limited in case of suicide, the insurer may show the true age or self-destruction, *New York Life Ins. Co. v. Hollender,* 38 Cal. 2d 73, 237 P.2d 510; *Stean v. Occidental Life Ins. Co.,* 24 N.M. 346, 171 Pac. 786. In such cases, the insurer is simply standing on the policy *as written.*

defendant can point to no provision of the policy stating that income stops after 15 years. On the contrary, the policy expressly provides for income for 20 years. The defense here is a contest *against* the terms of the policy as written.

The rule that insurance policies are construed against the insurer applies to an incontestability clause as to all others. *Dibble v. Reliance Life Ins. Co.,* 170 Cal. 199, 210, 149 Pac. 171, 174. Couple this with the elementary principle, *expressio unius est exclusio alterius,* for the incontestability clause provides that it shall not apply to a number of situations, carefully spelled out, but it does not specify that it shall not apply to claims of mistake. It follows that defendant may not contest on grounds of mistake.

V. The Doctrine of Anticipatory Breach Applies to This Case.

Defendant asserts (D. Br. 9) that the doctrine of anticipatory breach has no application to a contract for installment payments of money.

On the contrary, in every California case where the issue has been squarely presented, recovery on the basis of anticipatory breach has been allowed. E.g., *Caminetti v. Pacific Mutual Life Ins. Co.,* 23 Cal. 2d 94, 142 P.2d 741; *Guitron v. Rodriguez,* 105 Cal. App. 513, 288 Pac. 134.

In the *Guitron* case, affirming a judgment for plaintiffs, the court said (105 Cal. App. at 514; 288 Pac. at 134):

> "On this appeal the appellants insist that the action was premature because the contract called for monthly payments and these payments were not due at the time the suit was filed. In answer the respondents rely upon the well-settled rule that when the repudiation of an executory contract results in a violation of the contract '*in omnibus*' the injured party may treat the entire contract as at an end and sue for damages for the breach. (6 R.C.L., pp. 1024, 1025; 6 Cal. Jur., pp. 464, 465.)"

In the *Caminetti* case, the court said (23 Cal. 2d at 104; 142 P. 2d at 745):

> "It [the insurer] cannot perform under the non-cancellable [life insurance] policies it had issued. They have been in effect cancelled. The situation is thus analogous to *a breach by anticipatory repudiation.* Anticipatory breach is recognized in California. (6 Cal. Jur. 457.) *Upon the repudiation the promisee may immediately bring an action for future damages.*"

Defendant rests on the Restatement of Contracts, Para. 318, comment e, 12 Cal. Jur. 2d, Contracts, Para. 250, and *Cobb v. Pacific Mutual Life Ins. Co.,* 4 Cal. 2d 565, 51 P.2d 84. But the "statement of law [in texts] is no sounder than the cases that are cited to support the text" (Mr. Justice Peters, in 22 Cal. State Bar Journal, 175, 182). The cases cited in Cal. Jur. are the *Cobb* case, *Brix v. Peoples Mutual Life Ins. Co.,* 2 Cal. 2d 446, 41 P.2d 537, and *Flinn v. Mowry,* 131 Cal. 481, 63 Pac. 724.

Flinn v. Mowry is not pertinent because it was not a case of anticipatory breach at all. Defendant there simply failed to pay one or more installments but did not in addition repudiate the obligation to pay future installments.

Both the *Brix* and *Cobb* cases were actions on a *disability* policy providing for monthly payments so long as the insured was "wholly and continuously disable[d]" and "suffer[ed] total loss of time" (2 Cal. 2d at 447, 41 P.2d at 538; similarly 4 Cal. 2d at 567, 51 P.2d at 85). Therefore, as the *Brix* opinion says (2 Cal. 2d at 454), the insured's right to future payments depended upon the continued existence at each date in the future of conditions precedent which, in the nature of things, could not be determined until that future time occurred.

> "It is obvious that it [the failure to make a payment] does not work a breach as to the future benefits, since, as to such, the liability of the defendant has not become fixed, but

> remains contingent upon the condition of the plaintiff being such as to enable him to demand them." (2 Cal. 2d 447 at 453, 41 P.2d 540-541).

In *Caminetti v. Pacific Mutual Life Ins. Co.,* 23 Cal. 2d 94, 142 P. 2d 741, involving *life insurance,* the court distinguished the *Cobb* and *Brix* cases, saying that they

> "were concerned only with the question of the recovery of the payments that *might* become due *for continuance in the future of the existing disability,* as well as payments past due." (23 Cal. 2d at 104, 142 P.2d at 746).

Thus the *Caminetti* case, analogizing insolvency there to a present total repudiation, distinguished the case of an obligation to pay money which is unconditionally payable in the future from a case where the obligation to pay future installments is conditioned on the existence in the future of facts which might or might not occur. In the former the doctrine of anticipatory breach is applicable; in the latter, which is *Brix* and *Cobb,* it is not. Ours is the first type of case, for upon the death of the assured the obligation of the insurer became fixed, to pay plaintiff $50 per month until 1959. Its obligation is not speculative or contingent, and defendant so concedes (D. Br. 9).

4 Corbin on Contracts, §§ 962, 968, 969, places the insurance cases in two groups: first, the case here—"those in which the insurer undertakes to pay a definite sum of money at a specified future time"; second, "disability and annuity policies, providing for periodic payments for an indefinite time, it being wholly impossible to determine in advance the total amount that may eventually have to be paid." With respect to the first group of cases, he says (p. 880):

> "If the dicta to the effect that there can be no anticipatory breach of a unilateral contract were correct, there would be no right of action against an insurer for a repudiation in advance of the time for performance. Indeed, there are cases

holding in part on this ground, that an action will not lie for such a repudiation. In general, however, *it is well settled by ample authority that an action lies at once for an anticipatory repudiation by an insurer, either for the recovery of premiums paid or for damages.*" citing the *Caminetti* case among others.*

5 Williston on Contracts, p. 3742, gives the same explanation of the *Brix* and *Cobb* type of case.

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*4 Corbin on Contracts § 967 also states:

"It is well established that the fact that a contract is entirely unilateral at the time of repudiation by the defendant is not in itself sufficient to deprive the injured party of an immediate right of action; this is true, even though the contract is a unilateral contract for the mere payment of money instalments in the future. The contract, even though unilateral, may be conditional upon some performance to be rendered by the plaintiff. If it is thus conditional, the cases hold that the plaintiff can maintain an action at once for the anticipatory repudation, without performing the condition. It has been so held, even where the condition to be performed by the plaintiff is not any part of the agreed exchange for the performance promised by the defendant."

Here there still remains a condition to be performed by plaintiff. She must surrender the policy to defendant in Boston. (See the main policy, first paragraph, R. 31.)

Reply Brief of Plaintiff in Support of Cross-Appeal

On the cross appeal the issue is the construction of the warranty:

> "It is not necessary to employ any firm or person to collect the proceeds of this policy."

Defendant argues that our construction will not "bear up under close scrutiny" (Brief of Cross-Appellee in Answer to Cross-Appeal, p. 2). But, as already noted at p. 11, supra, an insurance contract must be construed most strongly in favor of the insured and the beneficiary. If it requires "close scrutiny" to draw out of the language of the policy the kind of construction the insurer desires, that construction must be rejected.

Defendant's construction would convert the warranty into a pious and delusive nothing. Defendant says (Brief on Cross Appeal, p. 4):

> "It says in effect 'come to us, when facts occur that relate to your policy; we will investigate and tell you if these facts entitle you to payments; we will aid you in filling out any applications and forms that are required; we will help you to perfect your claims and rights under the insurance contract. There is no need to secure aid from some other person in these matters, since as one of our services, we provide that aid ourselves.' "

Thus the beneficiary is to place herself in the insurer's hands. If the insurer should "tell" her wrongly that she had no rights, or that she is entitled to less than is legally hers, then, according to defendant, the beneficiary is out of luck. What a magnificent gesture on the part of the insurer! The emptiness of such a covenant, so construed, is demonstrated further by the fact that here,

in 1945, when a claim *was* presented, defendant did investigate and did tell plaintiff that it would pay in accordance with the terms of the Family Income provision as written, but 9 years later repudiated what it then told.

The lengths to which defendant is driven in its argument is shown by the following arrogant passage from its brief (p. 5):

> "Plaintiff would torture this phrase to say, 'whenever you want to pick a fight with me, feel free to go right ahead, for I will pay your expenses and attorney's fees.' "

If the beneficiary proves to be in error by losing her suit, of course she may not recover these items. But if the insurer's refusal to pay is established to be wrongful by judgment, it should pay under its warranty.

CONCLUSION

In *Kaufman v. New York Life Insurance Co.,* 172 Atl. 306, 315 Pa. 34, the court said:

> "If a policyholder cannot rely upon the face of his contract but must be continuously apprehensive of the fact that at the end of 20 years, he may be told a mistake had been made in the amount of capital upon which he came to rely, far more injury will result to the companies and the public than will be occasioned by requiring this defendant to stand the consequences of its own mistake." (172 Atl. at 309)

We submit that defendant's conduct has been high-handed, outrageous, and inexcusable, in refusing to honor its policy, in forcing plaintiff to litigation, in advancing a multitude of baseless arguments, and in taking an appeal from a judgment resting so thoroughly on findings of fact.

We submit that the judgment against defendant should be modified to allow recovery of damages measured by plaintiff's attorney's fees and expenses and otherwise affirmed, and that if necessary to reimburse plaintiff's expenses, such as the cost of printing briefs,

defendant should be taxed for a frivolous appeal under Rule 24(2) of this Court.

Respectfully submitted,

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